# ADJUSTMENT DISORDERS



## Introduction

An adjustment disorder is a behavioral response to a stressful event or variation in a child or adolescent's life that is not a healthy response to the event or change (Medical Center of Central Georgia, 2002). Youth who experience distress in excess of what is expected as a response to a stressor may even experience significant impairment in normal daily functioning and activities (Institute for Health, Health Care Policy and Aging Research, 2002).

Adjustment disorders in children are created by factors similar to those found in adults. Four factors that may contribute to the development of adjustment disorders are the nature of the stressor, vulnerabilities of the child, intrinsic factors, and extrinsic factors (Benton & Lynch, 2002).

In order to be considered and diagnosed as an adjustment disorder, the child's reaction must occur within three months of the identified event (Medical Center of Central Georgia, 2002). Typically, the symptoms do not last more than six months, and the majority of the children quickly return to normal functioning (United Behavioral Health, 2002). Adjustment disorders differ from post-traumatic stress disorder (PTSD) in that PTSD usually occurs in reaction to a life-threatening event and may be longer-lasting (Access Med Health Library, 2002). Moreover, the symptoms are not caused by another mental health disorder (Wood, 2003).

In 1997, the U.S. Department of Health and Human Services, the Substance Abuse and Mental Health Service Administration (SAMHSA) and Center for Mental Health Services conducted a client/patient sample survey of 8,000 children in mental health facilities. These children were randomly selected and surveyed in order to calculate national estimates regarding mental health services. The findings of the study indicated that 16% of the children who were admitted had an adjustment disorder (Institute for Health, Health Care Policy and Aging Research, 2002). In clinical

samples of children and adolescents, boys and girls are equally likely to be diagnosed with an adjustment disorder (American Psychiatric Association, 2000).

The following information is attributed to the University of Chicago Comer Children's Hospital (2005). Adjustment disorders occur at all ages; however, it is believed that characteristics of the disorder are different in children and adolescents than they are in adults. Differences are noted in the symptoms experienced, severity and duration of symptoms, and in the outcome. Adolescent symptoms of adjustment disorders are more behavioral, such as acting out, while adults experience more depressive symptoms.

## Classifications

The following six types of adjustment disorders are listed in the *Diagnostic and Statistical Manual, Fourth Edition* (*DSM-IV)*:

- Adjustment disorder with depressed mood: Symptoms are that of a minor depression.
- Adjustment disorder with anxious mood: Symptoms of anxiety are dominant.
- Adjustment disorder with mixed anxiety and depressed mood: Symptoms are a combination of depression and anxiety.
- Adjustment disorder with disturbance of conduct: Symptoms are demonstrated in behaviors that break societal norms or violate the rights of others.
- Adjustment disorder with mixed disturbance of emotions and conduct: Symptoms include combined affective and behavioral characteristics with mixed emotional features and with disturbance of conduct.
- Adjustment disorder not otherwise specified: This residual diagnosis is used when a maladaptive reaction that is not classified under other adjustment disorders but occurs in response to stress.

Source: Benton & Lynch, 2002.

Table 1 presents further information about these classifications.

## Causes and Risk Factors

Adjustment disorders are a behavioral or emotional reaction to an outside stressor and, accordingly, there is no single trigger between the stressor and the child's reaction to it (Medical Center of Central Georgia, 2002). Furthermore, because children possess varying dispositions, as well as different vulnerabilities and coping skills, it is impossible to attribute a single cause to this mental disorder. Thus, the developmental stage of the child and the strength of the child's support system may influence their reaction to a stressor (Medical Center of Central Georgia). There is no evidence to indicate that biological factors influence the cause of adjustment disorders. The common thread in anxiety disorders is stress as the precipitating factor (Benton and Lynch, 2002).

According to Benton and Lynch (2002), the most important factor in the development of an adjustment disorder is the vulnerability of the child. Vulnerability depends on the characteristics of both the child and the child's environment. A reliable assessment is not available to assess this variable.

*Table 1*

**Common Symptoms of Adjustment Disorders**

| |
|---|
| Adjustment disorder with depressed mood |
| depressed mood |
| tearfulness |
| feelings of hopelessness |
| Adjustment disorder with anxiety |
| nervousness |
| worry |
| jitteriness |
| fear of separation from major attachment figures |
| Adjustment disorder with anxiety and depressed mood |
| A combination of symptoms from both of the above subtypes is present (depressed mood and anxiety). |
| Adjustment disorder with disturbance of conduct |
| violation of the rights of others |
| violation of societal norms and rules (truancy, destruction of property, reckless driving, fighting) |
| Adjustment disorder with mixed disturbance of emotions and conduct |
| A combination of symptoms from all of the above subtypes are present (depressed mood, anxiety, and conduct). |
| Adjustment disorder unspecified |
| Reactions to stressful events that do not fit in one of the above subtypes are present. |
| Reactions may include behaviors such as social withdrawal or inhibitions to normally expected activities (i.e., school or work). |

Source: University of Chicago Comer Children's Hospital, 2005.

# Diagnosis

Children with adjustment disorder may have a wide variety of symptoms. Symptoms normally include several of those shown in Table 2.

*Table 2*

**Symptoms of Adjustment Disorders**

| | |
|---|---|
| Hopelessness | Withdrawal |
| Sadness | Inhibition |
| Crying | Truancy |
| Anxiety | Vandalism |
| Worry | Reckless driving |
| Headaches or stomachaches | Fighting |
| | Other destructive acts |

Source: Turkington, 1995.

Because most features of adjustment disorders are subjective (e.g., the stressor, the maladaptive reaction, the accompanying mood and feature, and the time and relationship between the stressor and the response), these disorders can be particularly difficult to diagnose (Benton and Lynch, 2002). A qualified mental health professional should assess the child for an adjustment disorder following a comprehensive psychiatric evaluation and interview with the child and the family

(Medical Center of Central Georgia, 2002). Specifically, a personal history appraising development, life events, emotions, behaviors, and the identified stressful event is performed during the assessment process in order to correctly diagnose the adjustment disorder (Medical Center of Central Georgia).

*Table 3*

**Characteristics of Adjustment Disorders**

- Adjustment disorders occur equally in males and females.
- Adjustment disorder stressors and symptoms may vary based on cultural influences.
- The characteristics of adjustment disorder in children differ from those in adults.
- Adolescent symptoms are more behavioral.
- Adult symptoms are more depressive.

Source: Medical Center of Central Georgia, 2002.

# Symptoms of Adjustment Disorders

According to the University of Chicago Comer Children's Hospital, in adjustment disorders, the reaction to the stressor is beyond a normal reaction, or the reaction significantly interferes with social, occupational, or educational functioning (2005). There are six subtypes of adjustment disorder that are based on the type of the major symptoms experienced. However, in children and adolescents, there may be a predominance of mixed, rather than discrete, symptom presentations (Newcorn & Strain, 1992). While each child may experience symptoms differently, the most common symptoms of each of the subtypes of adjustment disorder are described in Table 1.

Clinical symptoms in children and adolescents differ from those in adults and elderly persons (Benton & Lynch, 2005). Research has revealed that, in children and adolescents, more serious mental illnesses were present after five years of follow-up (Andreasen & Hoenk, as cited by Benton & Lynch).

# Comorbidity

Benton & Lynch (2002) indicate that adjustment disorders are most likely to occur with personality disorders, anxiety disorders, affective disorders, and psychoactive substance abuse disorder. More studies that focus on the association between adjustment disorders and other mental disorders, including substance abuse disorders, are needed. In children, adjustment disorders are also most likely to occur with conduct or behavioral problems (Wood, 2003). Patients with adjustment disorders may engage in deliberate self-harm at a rate that surpasses most other disorders and may be at an increased risk for substance abuse disorders (Benton & Lynch, 2005).

# Evidence-Based Treatments

The consensus on treating adjustment disorders is that, because an adjustment disorder is a psychological reaction to a stressor, the stressor must be identified and communicated by the child (Benton and Lynch, 2002). If the stressor is “eliminated, reduced, or accommodated" (Strain, as cited by Benton and Lynch), the child’s maladaptive response can also be reduced or eliminated. Accordingly, treatment of adjustment disorder usually involves psychotherapy that seeks to reduce the stressor, remove the stressor, or improve coping ability.

Treatments for adjustment disorders must be customized to the needs of the child, based on the child's age, health and medical history (Medical Center of Central Georgia, 2002). Other determining factors include the extent of the symptoms and the subtype of the adjustment disorder.

***Psychotherapy***

Psychotherapy is the treatment of choice for adjustment disorders, since the symptoms are a direct reaction to a specific stress (Turkington, 1995). However, the type of therapy depends on the needs of the child, with the focus being on addressing the stressors and resolving the problem.

Interpersonal psychotherapy (IPT) has the most support for treating children with adjustment disorders (Society of Clinical Child and Adolescent Psychology, 2006). For depressed teenagers, IPT is a well-established treatment (Mufson et al., 2004). IPT helps children and adolescents to address problems in their relationships with family members and friends so that they can become less depressed (Society of Clinical Child and Adolescent Psychology). Typically, IPT takes place in an individual format, in which the clinician works one-on-one with the child and his family. One study reported that adolescents who received IPT had significant reductions in their depressive symptoms and noted improvements in their social functioning (Mufson et al.) The largest treatment effect was noted in adolescents who are older and more severely depressed (Mufson et al.). IPT is an effective treatment for youth with adjustment disorders.

Brief treatment using cognitive-behavioral strategies shows promise (Society of Clinical Child and Adolescent Psychology, 2006). Cognitive-behavioral approaches are used to improve age-appropriate problem solving skills, communication skills, impulse control, anger management skills, and stress management skills (Medical Center of Central Georgia, 2002). Additionally, therapy assists with formatting an emotional state and support systems to enhance adaptation and coping (Benton and Lynch, 2002).

Research conducted by Strain, as cited by Benton and Lynch (2002), suggests that the goals of psychotherapy should include the following:

- Analyze the stressors that are affecting the child, and determine whether they can be eliminated or minimized;
- Clarify and interpret the meaning of the stressor for the child;
- Reframe the meaning of the stressor;
- Illuminate the concerns and conflicts the child experiences;
- Identify a means to reduce the stressor;
- Maximize coping skills; and
- Assist the child to gain perspective on the stressor and manage themselves and the stressor.

Stress management and group therapy are particularly beneficial in cases of high work/family stress. Family therapy is frequently utilized, with the focus being on making needed changes within the family system. These changes may include improving communication skills and family interactions and increasing support among family members (Medical Center of Central Georgia, 2002).

Preventive measures to reduce the incidence of adjustment disorders in children are not known at this time. However, early detection and intervention can reduce the severity of symptoms, enhance the child's normal growth and development, and improve the quality of life experienced by children or adolescents with adjustment disorders (University of Chicago Comer Children's Hospital, 2005).

### ***Pharmacological Treatment***

Medication is seldom used as a singular treatment for adjustment disorders because the child requires assistance in coping with the stressor that is causing the maladaptive behavior. However, targeted symptomatic treatment of the anxiety, depression, and insomnia that occur with adjustment disorders may effectively augment therapy, but is not recommended as the primary treatment for adjustment disorders. As cited in Benton and Lynch (2002), in a retrospective study of 72 adolescents having adjustment disorder, researchers (Ansari & Matar) found that disappointment in relationships was the primary stressor causing the disorder. Accordingly, the symptoms of the disorder must be addressed through psychotherapy, rather than pharmacology.

If a clinician determines that pharmacotherapy is necessary, short-term use of anxiolytics and hypnotics may be beneficial. Some research findings also suggest that selective serotonin reuptake inhibitors, or SSRIs, may help relieve youth depressive symptoms, especially in adolescents (Society of Clinical Child and Adolescent Psychology, 2006). A more detailed discussion of the use of antidepressants in treating children and adolescents is included in the "Antidepressants and the Risk of Suicidal Behavior" section of the *Collection*.

## Reactive Attachment Disorder

The American Academy of Child & Adolescent Psychiatry (AACAP) defines reactive attachment disorder (RAD) as a complex psychiatric illness that is characterized by serious problems in emotional attachments to others which usually presents by age 5 (AACAP, 2002). Attachment is the deep and enduring connection established between a child and caregiver in the first several years of life (Attachment Treatment & Training Institute, 2004). Early experiences with caregivers shape a child's core beliefs about self, others and life in general (Attachment Treatment & Training Institute).

According to the Attachment Treatment & Training Institute each year there are 800,000 children with severe attachment disorders (2004). When secure attachment between a child and a caregiver is disrupted, the child may begin to exhibit the symptoms described in Table 4.

*Table 4*

**Early Symptoms of Reactive Attachment Disorders**

| |
|---|
| ▪ Severe colic and/or feeding difficulties |
| ▪ Failure to gain weight |
| ▪ Detached and unresponsive behavior |
| ▪ Difficulty being comforted |
| ▪ Preoccupied and/or defiant behavior |
| ▪ Inhibition or hesitancy in social interactions |

Source: American Academy of Child & Adolescent Psychiatry (AACAP), 2002.

### *Causes and Risk Factors*

The prevalence of RAD is very rare and its cause is unknown (American Psychiatric Association, 2000). Moreover, RAD could go underdiagnosed because of its association with other disorders (New York University Study Center, 2001). However, children may have developed or experienced the following, as shown in Table 5.

*Table 5*

**Potential Causes of RAD**

- Severe problems or disruptions in their early relationships
- Physically or emotionally abused or neglected
- Inadequate care in an institutional setting or out-of-home placement
- Multiple or traumatic losses
- Changes in their primary caregiver

Source: American Academy of Child & Adolescent Psychiatry (AACAP), 2002.

According to the Child Welfare Information Gateway, children who have RAD may be superficially charming, indiscriminately affectionate, impulsive and hyperactive (2007). Table 6 lists the diagnostic criteria for RAD.

*Table 6*

**Diagnostic Criteria for RAD**

A. Markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before age 5 years, as evidenced by either (1) or (2):

1) persistent failure to initiate or respond in a developmentally appropriate fashion to most social interactions, as manifest by excessively inhibited, hypervigilant, or highly ambivalent and contradictory responses
2) diffuse attachments as manifest by indiscriminate sociability with market inability to exhibit appropriate selective attachments.

B. The disturbance in Criterion A is not accounted for solely by developmental delay (as in Mental Retardation) and does meet criteria for a Pervasive Developmental Disorder.

C. Pathogenic care as evidenced by at least one of the following:

1) persistent disregard of the child's basic emotional needs for comfort, stimulation, and affection
2) persistent disregard of the child's basic physical needs
3) repeated changes of primary caregiver that prevent formation of stable attachments (e.g., frequent changes in foster care)

D. There is a presumption that the care in Criterion C is responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the pathogenic care in Criterion C).

Source: American Psychiatric Association, 2000.

## *Subtypes*

There are two subtypes associated with RAD, as shown in Table 4.

*Table 4*

**Subtypes Associated with RAD**

- **Inhibited Type**—Predominant disturbance in social relatedness is the persistent failure to initiate and to respond to most social interactions in a developmentally appropriate way.
- **Disinhibited Type**—Predominant disturbance in social relatedness is indiscriminate sociability or a lack of selectivity in the choice of attachment figures.

Source: American Psychiatric Association, 2000.

### *Comorbidity*

The most common disorders that may co-occur with RAD are substance abuse, conduct disorder, and obsessive-compulsive disorder (National Youth Network, 2007). Moreover, RAD may resemble other disorders such as developmental delays, feeding disorder of infancy and early childhood, pica, or rumination disorder (Child Study Center, New York University Study Center, 2001).

### *Treatment*

Currently, there are limited evidence-based treatments for RAD. However, due to the nature and seriousness of RAD, the American Academy of Child & Adolescent Psychiatry (AACAP) suggests a comprehensive psychiatric assessment and individualized treatment plan for children who show signs of RAD (AACAP, 2002).

In conclusion, the AACAP (2002) recommends that parents who believe their child shows symptoms of RAD do the following:

- seek a comprehensive psychiatric evaluation prior to any treatment;
- understand the risks and benefits of any intervention; and
- seek a second opinion if questions or concerns about the diagnosis and/or treatment plan.

## Contraindicated Interventions

According to the AACAP, there is no scientific evidence to support rebirthing techniques, compression holding therapy, or other coercive interventions as effective treatment (AACAP, 2003). In fact, dangerous practices, such as adults forcibly holding a child in order to improve attachment, using hunger or thirst and/or forcing food or water upon the child, have resulted in six documented child fatalities (AACAP).

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**Organizations/Weblinks**

**American Academy of Child Adolescent Psychiatry (AACAP)**
http://www.aacap.org

**Attachment Treatment & Training Institute at Evergreen Psychotherapy Center**
http://www.attachmentexperts.com

**Child Welfare Information Gateway**
http://www.childwelfare.gov

**Mental Health.Com**
http://www.mentalhealth.com

**Mental Health Matters**
http://www.mental-health-matters.com/disorders/dis_details.php?disID=2

**New York University School of Medicine Child Study Center**
http://www.aboutourkids.org

**U.S. Department of Health and Human Services**
http://www.hhs.gov